DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96-40
2. STATE: MD
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 15, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 456

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ -0-
b. FFY 98 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
3.1-A page 10(a) (add 1.(A)(4)(a); 1.(B)(1);)
Page 10b (add 1.(D))
~~Page 10b~~
Page 19b (add 3.1(a)(1)(vii)(ai&))
4.19-A p. 15 (add XII A.4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page 19b
Attachment 3.1-A page 10a, ~~10b~~
Attachment 4.19-A page 15

10. SUBJECT OF AMENDMENT: Large Case Management and continued stay review of all inpatient admissions subject to admission certification.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT gl
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director, Department Of Social Services

15. DATE SUBMITTED:
12/30/96

16. RETURN TO:
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/31/96

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/15/96

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:

SPA CONTROL
Date Submitted 12/30/96
Date Received 12/31/96

cc:
Martin
Kadner

FORM HCFA-179 (07-92)

Instructions on Back

Revision: HCFA-PM-91-1991 (BPD) OMB No: 0938-

State/Territory: Missouri

Citation 3.1 (a) (1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1901 (a) (10) (D)		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902 (e) (7) of the Act		(vii)	Inpatient services that are being furnished to infants and of the children described in section 1902 (1) (1) (B) through (D), or section 1905 (n) (2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan for which the inpatient services are furnished.
		(ai)	Effective with admissions on or after October 15, 1996, recipients whose inpatient care is currently subjct to admission certification will also be subject to Continued Stay Review (CSR). Payment for the hospital stay will be made according to the lessor of the actual discharge date or the cease payment date assigned by the Medical Review Agent. All hospital stays for children (except newborn admissions) will be reviewed and approved by the Medical Review Agent.
1902 (e) (9) of the Act	/_/	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.
1902 (a) (52) and and 1925 of the Act		(ix)	Services are provided to families eligible under Section 1925 of the Act as indicated in item 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State Plan TN# _____
Supersedes TN# _____

Effective Date _____
Approval Date _____
HCFA ID: _____

State Plan TN# 96-40
Supersedes TN# 92-06

Effective Date October 15, 1996
Approval Date JUN 06 2001

State Missouri

(2) An average length-of-stay schedule, as developed by the Medicaid agency, for limited categories of rehabilitation services provided in Specific facilities;

(3) An average length-of-stay schedule, as developed by the Medicaid agency, for liveborn infants according to type of birth.

(4) For infants who are less than one (1) year of age at admission, all Medically necessary days will be paid at any hospital. For children who Are less than six (6) years of age at admission and who receive services from a disproportionate share hospital, all medically necessary days will be paid.

(a) Effective for admissions on or after October 15, 1996, the Medical Review Agent will perform continued stay reviews (CSR) for children under 1 (except newborn admissions) and all children under age six admitted to disproportionate share hospitals.

(5) Continued stay review will be performed for alcohol and drug abuse detoxification services to determine the days that are medically necessary and appropriate for inpatient hospital care.

; or

(B) The number of days certified as medically necessary by the Medical Review Agent.

(1) Effective for admissions October 15, 1996 and after, the Medical Review Agent will be responsible for continued stay review of all inpatient admissions subject to admission certification, large case management for high-cost patients, and quality of care review of selected cases. Payment for the hospital stay will be made according to the lessor of the actual discharge date or the cease payment date assigned by the Medical Review Agent.

Inpatient hospital admissions that were previously exempt will remain exempt from Admission certification.

The Medical Review Agent will continue to review continued stay requests for alcohol and drug detoxification cases.

; or

(C) The number of days billed as covered service by the provider.

(D) Effective July 1, 1996, individuals enrolled with an MC+ managed health care plan whose inpatient services within a play year have reached the $40,000 threshold or whose inpatient services can reasonably be expected to reach $50,000 during that plan year will be referred to the Medical Review Agent for monitoring of the MC+ Health Plan's Large Case Management interventions. When an MC+ enrollee's inpatient health care expenses reach $50,000, Medicaid will reimburse the MC+ health plan for 80 percent of all inpatient care expenses for the remainder of the plan year. The MC+ health plan will retain financial responsibility for 20 percent of inpatient care costs and will continue to case manage all MC+ covered benefits. Large case management will ensure that all services provided to MC+ enrollees are appropriate and cost effective.

Inpatient psychiatric care provided to an MC+ enrollee after his or her 30/20 plan limit has been exhausted for that plan year will be subject to admission certification and continued stay review by the Medical Review Agent.

In administering this limitation, counting of the days which may be allowable shall be from the beginning date of an admission which has been certified, or exempted from certification, and for a continuous period of hospitalization or if later, the beginning date of recipient Medicaid eligibility or the first day of Title XIX coverage following exhaustion of Title XVIII Part A benefits.

Certification of inpatient hospital admissions occurring on and after November 1, 1989 shall be conducted in accordance with the provisions of state rule 13 CSR 70-15.020. The medical review agent for the state applies criteria for medical necessity and appropriateness of the admission. Denial of certification of admissions subject to review will result in program non-coverage of inpatient services if provided, or recovery if review is retrospective to provision of service and admission certification is denied.

State Missouri

Coverage of services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Bone marrow, heart, kidney, liver and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Cornea transplants are covered without a requirement of prior authorization.

PHYSICIAN ATTESTATION POLICY FOR HOSPITALS

Missouri Medicaid's requirements are the same as Medicare Program requirements for physician attestation statements.

2.a. Outpatient Hospital Services

Coverage of services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Payment is made to a hospital for physician's services only if the physician is hospital based and has a signed Medicaid participation agreement.

2.b. Rural Health Clinic Services

Payment will be made for services provided in a rural health clinic only when that clinic has Been certified for participation in the Title XVIII Medicare Program by the Bureau of Hospital Licensing and Certification of the Missouri Department of Health or by comparable agencies in other states.

2.c. Federally Qualified Health Center (FQHC) Services

(1) Provider Participation. To be eligible for participation in the Missouri FQHC program, a provider must submit proof satisfactory to the Division of Medical Services that it meets the following conditions:

(A) The health center receives a grant under Section 329, 330 or 340 of the Public Health Services Act or the Secretary of Health and Human Services (HHS) has determined the health center qualifies by meeting other requirements. If a FQHC identified in the grant Has multiple sites, the

XII. Inappropriate Placements

A. The hospital per-diem rates as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when he is only in need of nursing home care.

1. If a hospital has an established ICF/SNF or SNF only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital's ICF/SNF or SNV only rate.

2. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement of nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.

3. No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.

4. Effective for admissions October 15, 1996 and after, the Hospital Utilization Review Committee will be responsible for continued stay review of all inpatient admissions subject to admission certification, large case management for high-cost patients, and quality of care review of selected cases. Where appropriate, the Medical Review Agent will make recommendations for alternative plan of care measures.

XIII. Out-of-State and In-State Federally-Operated Hospital Reimbursement

A. Effective for admissions beginning on or after April 1, 1994, inpatient services for Missouri Medicaid recipients age twenty-one (21) or older in hospitals located outside Missouri and federally-operated hospitals located within Missouri will be reimbursed at the lower of --

1. The charges for those services; or

2. The individual recipient's days of care (within benefit limitations) multiplied by the Title XIX per-diem rate of three hundred forty-five dollars and thirteen cents ($345.13).

B. Effective for admission beginning after April 1, 1994, inpatient services for children under the age of twenty-one (21) in hospitals located outside Missouri will be reimbursed at the lower rate of -

1. The charges for those services; or

Substitute per letter dated 3/21/97

Revision: HCFA-PM-91-1991 (BPD) OMB No: 0938-

State/Territory: Missouri

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Effective Date _____
Approval Date JUN 06 2001
HCFA ID: _____

State Plan TN# 96-40 Effective Date October 15, 1996
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XIII. Out-of-State and In-State Federally-Operated Hospital Reimbursement

A. Effective for admissions beginning on or after July 1, 1987, inpatient services for hospitals located outside the State of Missouri and federally-operated hospitals located within the state of Missouri will be reimbursed at the lower of --

1. The charges for those services; or

2. The individual recipient's days of care (within benefit limitations) multiplied by The Title XIX per-diem rate established July 1, 1986, as the weighted average per-diem rate determined for Missouri facilities (excluding state mental health Facilities and federally-operated hospitals) as of June 1, 1986 as increased by the annual inflation index for in-state hospitals calculated in accordance with Section 1. of this rule.

B. There will be no adjustments or exemptions to this per-diem rate and no individual rate reconsideration will be performed.